Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

IRVING COPPELL SURGICAL HOPSITAL
400 W I-635
IRVING TX 75063

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-7283-01

MFDR Date Received
MARCH 26, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier denies, no acknowledgment to support, illegible EOB. We have contacted the carrier to received additional information and the adjustor indicates that she is not sure but denial due to ANSI codes. Services were authorized and billed appropriately. Carrier refuses to pay or provide sufficient reasoning behind denial."

Amount in Dispute: $12,333.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: " Denial is based upon extent of injury per CCH decision & order. Peer review attached & CCH decision."

Response Submitted by: Sedgwick CMS, 600 N. Pearl, #1200, Dallas, TX 75201

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2008	Outpatient Hospital Services	$12,333.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 14, 2008 and December 18, 2008

- The initial EOB denied services using ANSI Reason Codes 0C2, 116, 113, 4Y8 without text to explain the reason for reduction/denial. On December 18, 2008 Sedgwick CMS review the charges and used the following denial reasons:
- W1 – Workers Compensation State Fee Schedule adjustment.
- 216 – Based on the findings of a review organization.
- 219 – Based on extent of injury.
- 5110 – Service denied per claims examiner's instructions.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Did the requestor document that the treatment to the injured worker was for the compensable injury?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes "219 – Based on extent of injury" and "216 – Based on findings of a review organization." The insurance carrier submitted four PLN-11's denying the extent of the injured workers injury. The PLN-11, dated January 16, states, "Sedgwick CMS on behalf of Blockbuster accepts the left wrist sprain but disputes that the injury extends beyond the accepted injury and/or any other body part, condition or injury." On July 3, 2008 another PLN-11 was submitted to the Division stating "Sedgwick CMS on behalf of America Home Assurance dispute that the employee's injury extends beyond a sprain/strain to the left wrist, to include tenosynovitis of the left extensor carpiradialis longus, entensor carpi radialis brevis and extensor pollicis longus tenson sheath. Also degenerative glattening with longitudinal tear of extensor carpi ulnaris tendon and ganglion cyst along the palmar aspect of the distal radious and second capral/metacarpal joint." On October 7, 2008 submitted a PLN-11 stating "Sedgwick CMS on behalf of America Home Assurance received notice on 9/2/08 indicating that the employee had dental work on 6/2/08. Carrier respectfully disputes that dental work injuries are related to the compensable injury of left wrist sprain/strain." The last PLN-11 was submitted on February 19, 2009 stating "Sedwick CMS on behalf of America Home Assurance admits that the employee sustained a left wrist sprain/strain injury and Tenosynovitis of the left wrist. Sedgwick CMS disputes that the employee's injury includes psychological conditions as a result of the compensable work related injury.

   A contested case hearing was held on October 21, 2008 to decide the disputed issue: Does the compensable injury of January 14 2008 include left wrist de Quervain's tenosynovitis? The insurance carrier's agent submitted a copy of the Hearing Officers decision that stated "The compensable injury of January 14, 2008 includes left wrist tenosynovitis but does not include left wrist de Quervain's tenosynovitis."

   The documentation submitted by the insurance carrier supports that the treatment provided was not part of the compensable injury.

2. The requestor billed using ICD-9 codes 727.89 – Other disorders synovium tendon and bursa other and ICD-9 355.9 – Mononeuritis of unspecified site. According to the *Stedman's Medical Dictionary,* the definition of Tenosynovitis is inflammation of a tendon and its enveloping sheath. De Quervain tenosynovits is inflammation of the tendons of the first dorsal compartment of the wrist, which includes the abductor pollicis longus and extensor pollicis brevis; diagnosed by a specific provocative test (Finkelstein test). Review of the operative report documents that two of the 10 operations performed were Tenolysis, extensor pollices longus tendon, left thumb and Tenolysis, extensor pollices brevis tendon, left thumb.
3. Review of the requestors documentation does not support treatment was for the compensable injury. As a result, reimbursement is not warranted.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 22, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.